**Practice:** **Today's Date:**

**Name:** _____ **DOB:** _____ **Chart Number:** _____

**Sex:** ☐M ☐F **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced **SS#:** _____

**E-mail:** _____ **Spouse/Partner Name**: _____

*E-mail newsletters, reminders, statements, etc.* **Emergency Name:** _____ **Phone:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Home #:** _____ **Cell #:** _____ **Other #:** _____

**Employer:** _____ **Phone:** _____

**Employer Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Primary Insurance:** _____ Are you the insured? ☐Yes ☐No

***Insured Information***

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

**Secondary Insurance:** _____ Are you the insured? ☐Yes ☐No

***Insured Information***

Subscriber Name: _____ Relationship to insured: ☐Spouse ☐ Child ☐Self ☐ Other

Phone #: _____ Sex: ☐Male ☐Female DOB: ___/___/___

Address: _____

Policy ID: _____ Group ID: _____ Employer: _____

**How did you find out about our practice?** ☐ Physician ☐ Internet ☐ Telephone book ☐ Family member ☐ Friend ☐ Other: _____

**What is the reason for your visit today?** _____

_____ **Result of accident or work injury?** ☐Yes ☐No

**How long has this bothered you?** 1 2 3 4 5 6 7 ☐ days ☐ weeks ☐ months ☐ years

**What treatments have you tried & have they been effective?** _____

_____

**On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10**

**The pain quality is:** ☐burning ☐constant ☐dull ☐sharp ☐shooting ☐throbbing ☐tingling Other:_____

**PLEASE READ AND SIGN**

The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

# History and Physical

**Name:** _____ **DOB:** _____ **Chart Number:** _____

**Medical History:**
☐ Alcoholism ☐ Blood disorders ☐ Circulation problems ☐ Musculoskeletal ☐ Breathing issues
☐ Liver ☐ Sleep apnea ☐ Gout ☐ Allergies ☐ Heart disease ☐ Asthma
☐ Heart murmur ☐ Stomach/bowel ☐ Depression ☐ Anxiety disorder ☐ Mental illness ☐ Kidney disease
☐ Blood clot ☐ High cholesterol ☐ High blood pressure ☐ Cancer ☐ Hepatitis
☐ Neuropathy *(specify)* _____ ☐ Thyroid disease *(specify)* _____ ☐ Diabetes (type 1, type 2)
☐ Arthritis *(specify)* _____ ☐ other (*specify)* _____ ☐ HIV ☐ CVA
**Are you pregnant?** ☐ Yes ☐ No **Are you nursing?** ☐ Yes ☐ No ☐ Skin disorders ☐ Stroke

**Surgical History** ☐None ☐Appendectomy ☐ C-Section ☐Angioplasty ☐Bypass ☐Cataracts ☐ Cholecystectomy
Have you ever had any surgical procedures on foot/ankle or anywhere else on your body? ☐ Yes ☐ No
If yes, please describe: _____
Do you have any artificial joints? ☐ Yes (where? _____) ☐ No Do you have an artificial heart valve? ☐ Yes ☐ No

**Social History**
Do you smoke? ☐Yes ☐No If yes how many packs per day? ☐1 ☐2 ☐3 ☐4 ☐5 For how long? _____
Do you drink alcohol? ☐Yes, everyday (5-7 days/week) ☐Yes, occasionally/socially ☐No/Rarely
Substance abuse: ☐Yes, I have a current substance abuse problem. Please specify: _____
☐Yes, I had a past substance abuse problem. Please specify: _____
☐ No, I have never had a substance abuse problem
What is your occupation? _____ Does it involve mostly ☐ standing or ☐sitting
Do you exercise regularly? ☐ No, I do not exercise regularly ☐ Yes, I do the following regular exercise: _____
_____

**Family History** Is there any family history *(blood relative)* of: *(Please indicate family member)*

| | | | |
|---|---|---|---|
| ☐ Alzheimer's | _____ | ☐ Depression | _____ |
| ☐ Arthritis | _____ | ☐ Diabetes | _____ |
| ☐ Bleeding disorders | _____ | ☐ Emphysema | _____ |
| ☐ Blood clot | _____ | ☐ Heart disease | _____ |
| ☐ Cancer | _____ | ☐ High Blood Pressure | _____ |
| ☐ Cataracts | _____ | ☐ Neurological | _____ |
| ☐ Circulation problems | _____ | ☐ Strokes | _____ |
| ☐ Other (specify): | _____ | | |

**Review of Systems** *(Please check the box if you currently have any of these symptoms or check "NONE")*

| | | | | | |
|---|---|---|---|---|---|
| **Cardiovascular** | ☐leg pain when walking | ☐fever | ☐chest pain/pressure | ☐leg swelling | ☐cold hands/feet |
| | ☐fainting | ☐palpitations | ☐vascular disease | ☐valve problems | ☐**NONE** |
| **Genitourinary** | ☐blood in urine | ☐hesitancy | ☐incontinence | ☐increased urgency | |
| | ☐decreased frequency | ☐excessive urination | ☐kidney disease | ☐kidney stones | ☐**NONE** |
| **Gastrointestinal** | ☐abdominal pain | ☐heartburn | ☐blood in stool | ☐vomiting | ☐ulcers ☐constipation |
| | ☐diarrhea | ☐trouble swallowing | ☐decrease appetite | ☐increase appetite | ☐**NONE** |
| **Integumentary** | ☐athletes foot | ☐nail abnormalities | ☐keloids | ☐itchiness | ☐dry, scaly skin ☐**NONE** |
| **Hematologic** | ☐lower leg ulcers | ☐sickle cell disease | ☐anemia | ☐blood thinners | ☐clotting disorders ☐**NONE** |
| **Neurological** | ☐tingling | ☐weakness | ☐seizures | ☐numbness | ☐headaches |
| | ☐tremors | ☐paralysis | | | ☐**NONE** |
| **Musculoskeletal** | ☐back pain | ☐joint swelling | ☐muscle weakness | ☐muscle pain | ☐neck pain |
| | ☐sciatica | ☐joint stiffness | ☐joint pain | ☐joint instability | ☐arthritis ☐**NONE** |
| **Respiratory** | ☐chest pain | ☐wheezing | ☐COPD | ☐coughing | ☐snoring |
| | ☐shortness of breath | ☐emphysema | | | ☐**NONE** |

**PLEASE READ AND SIGN**
The above information is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above.

Patient Signature: _____ Date: _____

**Practice:** **Today's Date:**

**Name:** _____ **Chart #:** _____ **Date of birth:** _____

**Race:** _____ ☐ I prefer not to answer ☐ I do not know

*(White, American Indian, Asian, Black or African, Native Hawaiian, Hispanic, etc.)*

**Ethnicity:** _____ ☐ I prefer not to answer ☐ I do not know

**Preferred Language:** _____ ☐ I prefer not to answer

**Pharmacy Name:** _____ **Pharmacy Phone:** _____

Pharmacy Address: _____ City, State, Zip: _____

**Primary Care Physician:** _____ Phone: _____ Date Last Seen: _____

Address: _____

**Referring Physician:** _____ Phone: _____ Date Last Seen: _____

Address: _____

## Privacy Information Preferences

Do you want to be exempt from public reporting? ☐ Yes ☐ No Can we send mail to the address on file? ☐ Yes ☐ No

Can we call the phone number on file? ☐ Yes ☐ No Can we leave voicemail on machine? ☐ Yes ☐ No

Will you allow us to send internet based (e-mail) delivery of reminders and newsletters? ☐ Yes ☐ No

If yes, please provide your e-mail address: _____

Who can we leave messages with? ☐ Wife ☐ Husband ☐ Daughter ☐ Son ☐ Other: _____

Name(s): _____

## Smoking Status

☐ Current Every Day Smoker ☐ Never Smoker

☐ Current Some Day Smoker ☐ I decline to answer

☐ Former Smoker

## Vital Signs

Blood Pressure: _____ / _____

Height: _____ Weight: _____

## Current Medications

☐ No Known Medications ☐ I take the following medications:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Use the back of this form if more room is needed

## Allergies

☐ No Known Allergies ☐ No Known Drug Allergies

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Name: _____ Reaction _____

Use the back of this form if more room is needed

**Last Flu Shot Date:** _____ **Did you get a pneumococcal vaccination?** ☐ Yes ☐ No

**PLEASE READ AND SIGN:** The information on my intake form(s) is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. *(Assignment of Benefits)*: I authorize payment of medical benefits to the practice named above. *(Release of Information)*: I authorize the release of any medical information necessary to process this claim. *(HIPAA Privacy)*: I acknowledge that I received my HIPAA Privacy Practices Notice. *(Medication History)*: I authorize the Doctor's office to retrieve my medication history.

Patient Signature: _____ Date: _____